

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 26, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001748	Date of Injury:	04/05/2013
Claim Number:	[Redacted]	Application Received:	09/25/2015
Assignment Date:	10/16/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	03/20/2015 – 03/20/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104 and 96101		

Dear [Redacted]

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above workers’ compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$195.00 for the review cost and \$4,004.48 in additional reimbursement for a total of \$4,199.48. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$4,199.48** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

Paul Manchester, M.D., M.P.H.
Medical Director

cc: [Redacted]
[Redacted]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- Med Legal Official Medical Fee Schedule

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider seeking remuneration for ML104-94-95 and 96101 submitted for date of service 03/20/2015.**
- The Claims Administrator denied reimbursement pending documentation.
- Authorization from Legal Parties to Provider confirms request for “**Panel QME,**” services, relating to ““psych issues.””
- The following requests are noted on the 03/03/2015 Authorization:
 - Psychological Evaluation
 - Perform any diagnostic tests necessary.
 - Address 7 direct issues/questions/concerns including:
 - Causation
 - Apportionment
- **ML104 Med. Legal Definition:** “An evaluation which requires four or more of the complexity factors...”
- Med Legal OMFS ML104 criteria when compared to abstracted information provided on the **Fee Disclosure** and **QME Report** revealed the following:
 1. Two or more hours of face-to-face time by the physician with the injured worker. **“1hours 1 minute.” Criteria Not Met**
 2. Two or more hours of record review by the physician **“3.0 hours.” Criteria Met**
Research cited pates 41 - 53

3. Two or more hours of medical research by the physician. Provider indicates “5.5 ours.” **Criteria Met**
 4. Four or more hours spent on any combination of **two complexity** factors (1)-(3), which shall count as **two** complexity factors.
 - Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor. **Criteria Met**
 5. Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors. **Criteria Met**
 6. Addressing the issue of medical causation upon written request of the party or parties requesting the report, or if a bona fide issue of medical causation is discovered in the evaluation. **Criteria Met.**
 7. Addressing the issue of Apportionment under the following circumstances: **Criteria Not Met. Page 35** of PQME Report Provider indicates Apportionment “deferred.”
 - LC § 4663 (c) In order for a physician's report to be considered complete on the issue of permanent disability, **the report must include an apportionment determination.** A physician shall make an apportionment determination by finding what **approximate percentage** of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.
 8. Addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances: **Criteria Not Met.**
 9. A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation. **Criteria Met**
 10. Addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610. **Criteria Not Met.**
- Criteria Met for ML104, Units as Follow:
 - 1 hour Face-to-Face = 4 units
 - Activities of Daily Living = Included in Face-to-Face Time and/or Record Review
 - 3 hours Record Review = 12 Units
 - 5 hours Report Prep = 20 Units
 - 5.5 hours Med Research = 22 Units
 - **ML104 Total Units = 58**
 - **CPT 96101** Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, mmpi, rorschach, wais), **per hour** of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
 - Documentation for Psychological Testing is separately identified and is not included in the overall units for ML104.

- Documented Psychological Testing Hours = 4 reimbursable hours (per hour code).
- **Based on the aforementioned documentation and guidelines, reimbursement is recommended for ML104-95 & 96001.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML104 & 96101

Date of Service: 03/20/2015							
Med Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
ML104	\$3,812.50	\$0.00	\$3,812.50	N/A	61	\$3,625.00	Med Legal OMFS
96101	\$474.35	\$0.00	\$473.35	N/A	4.5	\$379.48	Med. Legal OMFS

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